REVISION DATES: 10/05/2016; 05/31/2012

The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual and AHCCCS Administrative Code A.A.C. R9-28-201 et seq. and R9-22-201 et seq.

The AHCCCS Medical Policy Manual is available on the AHCCCS Web site at www.azahcccs.gov.

Covered Services

The Arizona Long Term Care System (ALTCS) provides care and services for eligible individuals who are elderly and/or those with physical or developmental disabilities. ALTCS provides institutional care and home and community based services to recipients who have been determined to be at risk of institutionalization. Covered services include the following when considered medically necessary:

1. Medical services
2. Institutional services, including:
   a. Nursing facilities
   b. Inpatient psychiatric facilities for individuals under age 21 (RTCs)
   c. Intermediate care facilities for person with Intellectual Disabilities (not covered for fee-for-service recipients)
3. Home and community based services (HCBS)
4. Hospice services
5. Speech, physical, and occupational therapies
6. Behavioral health services
7. Durable medical equipment and medical supplies
8. Private duty nursing services
9. Limited Dental Services (effective 10/01/2016 service date)

Coverage Limitations

Private rooms in nursing facilities require physician orders and must be medically necessary.

Respite care is limited to 600 hours per benefit year.

Attendant Care, when provided by the recipient's spouse, is limited to no more than 40 hours per week.

Therapeutic leave days are limited to nine days per contract year.

Bed hold days for recipients admitted to a hospital for a short stay are limited to 12 days per contract year.

Home based services not provided when recipient is in the hospital.

Eligibility

Application for ALTCS may be made at any of the ALTCS offices located throughout Arizona (See Exhibit 14-2). An individual may submit his or her own application or may have a family member or other representative make the application.

Applicants must meet financial and medical eligibility requirements. When it appears that an applicant is financially eligible for ALTCS, medical eligibility is determined by a Preadmission Screening (PAS). The PAS measures functional and medical disability to determine if the applicant is at risk of institutional placement.

Once determined eligible, recipients who are elderly or have physical disabilities (referred to as EPD recipients) are enrolled with a program contractor in their county of residence. American Indian EPD recipients who maintain a residence on the reservation are enrolled with a tribal contractor and receive services on a fee-for-service basis. All persons with developmental disabilities (referred to as DD recipients) are enrolled with the Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

Case Management

All ALTCS recipients are assigned a case manager who is responsible for identifying, planning, obtaining, and monitoring appropriate and cost-effective medical and medically related services.

The AHCCCS Administration maintains Intergovernmental Agreements (IGA) with seven tribal governments for the delivery of ALTCS case management services to tribal EPD recipients with ties to their respective reservations. The seven tribal governments are the Pascua Yaqui Tribe, Gila River Indian Community, Tohono O'Odham Nation, San Carlos Apache Tribe, White Mountain Apache Tribe, Navajo Nation, and the Hopi Tribe.

EPD recipients of other tribes without an IGA are enrolled with Native Health. Native Health and the tribal governments (referred to as Tribal Contractors) employ case managers who are responsible for coordinating ALTCS services to recipients. The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal ALTCS recipients enrolled. All other services are provided and reimbursed on a fee for service basis.

Case manager authorization of ALTCS services is required unless:

1. The recipient has Medicare or other insurance coverage *and* the services are covered by Medicare or the other insurance, or

2. Services were provided during a period when the recipient was retroactively eligible.

Among the ALTCS services that require authorization are:

1. Medically necessary non-emergency transportation (when mileage exceeds 100 miles)

2. Homemaker services, attendant care, and personal care

3. Respite (in home and nursing facility)

4. Home health nurse and home health aide

5. Therapy (occupational, speech, respiratory, and physical)

6. DME, all orthotic and prosthetic devices, and medical supplies (orthotics are not covered for recipients age 21 years and older)

7. Adult day health and home delivered meals

8. Nursing facility services, including bed hold and therapeutic leave days

9. Acute Care services

Acute care services such as in-patient hospitalizations for non-Medicare covered recipients and outpatient surgery must be authorized by the AHCCCS Care Management Systems Unit (CMSU). Tribal case managers are not involved with acute care service authorization.

To arrange services, the case manager first contacts the appropriate provider. Once arrangements are confirmed, the case manager enters the authorized services in the Case Management Service Plan in the AHCCCS system. An authorization letter is automatically sent to the provider (except nursing facilities) verifying the services authorized.

The information entered on the provider's claim form must match what has been authorized and listed on the confirmation letter. The AHCCCS claims system matches the claim information against established authorizations and identifies the appropriate case manager authorization for the services that require authorization. If there are any discrepancies between the service billed and the authorized service, the system will not find the appropriate authorization, and the claim will be denied. (See Exhibit 14-1 for a sample authorization letter.)

Nursing Facility Services

Nursing facilities provide care for recipients who are chronically ill and/or for those recuperating from illness that need nursing care but not hospitalization. Many facilities offer several levels of care and various specialized services such as therapies. A limited number serve patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems. (Refer to Chapter 15, Nursing Facility Services, for a detailed description of nursing facility services as well as the AMPM Chapter 1200)

Home and Community Based Services (HCBS)

Home and community based services (HCBS) are services for ALTCS recipients residing in their homes who would otherwise require supervision and assistance through nursing facility services. (Refer to the AMPM Chapter 1200 for detailed description of these services)

Covered HCBS services include:

1. Assisted living facility
   ALTCS covers services, except room and board, for EPD recipients who are physically or functionally unable to live independently in the community but can have their needs met safely while residing in an assisted living facility.
   - Assisted living homes provide room, board, personal care and supervision for up to 10 adults.
   - Adult foster care homes provide room, board, personal care, and supervision for one to four adults in a family environment
   - Assisted living centers provide room, board, personal care, and supervision for more than 10 adults.

2. Adult day health services provide supervision, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and other health-related services.

3. Attendant care services provide assistance with homemaking, personal care and general supervision for a recipient in his/her own home as an alternative for those who may otherwise have to go to a nursing facility.

4. Home delivered meal services provide for one meal per day containing at least 1/3 of the Recommended Dietary Allowance to be delivered to a recipient's residence (Covered only for EPD recipients).

5. Homemaker services provide assistance to a recipient in the performance of activities related to household maintenance.

6. Home health services provide intermittent in-home care for recipients such as nursing services, home health aides, medical supplies, equipment and appliances, and therapies (See Chapter 13, Home Health Care Services).

7. Hospice services provide supportive care for terminally ill recipients and their family or caregivers in the home or in an institution.

8. Personal care services provide assistance to recipients who need help doing essential activities of daily living (i.e., eating, bathing, dressing).

9. Respite services provide short term or intermittent care and supervision in order to provide an interval of rest or relief for family members, up to 600 hours per benefit year.

   Short-term in-home respite service cannot exceed 12 hours on a specific date. When necessary and authorized, more than 12 hours of respite in a 24 hour period can be authorized as continuous respite.

Therapy Services

AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a physician, and provided by or under the direct supervision of a licensed therapist.

Occupational Therapy
Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.

AHCCCS covers medically necessary OT services provided to all recipients who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the recipient's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient occupational therapy services are covered for EPSDT and ALTCS recipients.

Occupational Therapy services may include, but are not limited to:

1. Cognitive training
2. Exercise modalities
3. Hand dexterity
4. Hydrotherapy
5. Joint protection
6. Manual exercise
7. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
8. Perceptual motor testing and training

9. Reality orientation
10. Restoration of activities of daily living
11. Sensory reeducation, and
12. Work simplification and/or energy conservation.

Physical Therapy

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices. A Physical Therapy Assistant (under the supervision of the PT according to A.A.C. 24, Article 3) must be certified by the Arizona Physical Therapy Board of Examiners. Out of state physical therapists providing services to AHCCCS recipients outside the State of Arizona must meet applicable State and/or Federal requirements.

Physical Therapy (PT) is an AHCCCS covered treatment service to restore or improve muscle tone, joint mobility or physical function. Physical therapy prescribed only as a maintenance regimen is excluded.

AHCCCS covers medically necessary PT services for recipients in an inpatient or outpatient setting, when services are ordered by the recipient's PCP/Attending physician. Inpatient PT services are covered for all recipients who are receiving inpatient care at a hospital (or a nursing facility). Outpatient PT services are covered for EPSDT, ALTCS and KidsCare recipients when medically necessary.

In accordance with AHCCCS Administrative Rules A.A. C. R9-22-215 and R9-28-202 outpatient PT services are covered for adult recipients, 21 years of age and older (Acute and ALTCS) as follows:

Service limits will be applied to physical therapy CPT codes 97001-97546.
A physical therapy visit is defined as:

1. An occurrence of CPT codes 97001-97546
2. Billed on form types 1500 and UB-04 outpatient
3. Any provider type except:

13	Occupational Therapist
22	Nursing home

4. Any place of service excluding:

31	Nursing home
32	Nursing facility
33	Custodial facility

The service limits are:

- 15 PT visits per contract year (10-1 thru 9/30) for habilitation (to attain or acquire a particular skill for function never learned or acquired and maintain that function once acquired); and
- 15 PT visits per contract year for rehabilitation (to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored).

When the recipient is Dual Eligible (also known as Medicare Primary, non QMB Dual) AHCCCS is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to the PT service limits. In the event that the PT service limit is reached prior to the Medicare maximum dollar amount, AHCCCS will pay the Medicare cost sharing up to the service limit per contract year.

1. As part of their Medicare benefit, recipients may opt to receive services up to Medicare maximum dollar amount; **however** the Medicare cost sharing for any visits beyond the service limit allowed by AHCCCS are the recipient's responsibility.

2. In the event that the recipient exhausts the Medicare dollar maximum amount prior to utilizing the PT service limit, AHCCCS will continue to cover the additional visits up to the service limit maximum.

When the recipient is QMB Dual AHCCCS is responsible for Medicare cost sharing up to Medicare maximum dollar amount.

1. In the event that the PT service limit is reached prior to the Medicare maximum dollar amount, AHCCCS will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

2. In the event that recipient exhausts the Medicare maximum dollar amount prior to utilizing the PT service limit allowed, AHCCCS will continue to cover the additional visits up to the service limit maximum.

Definitions:

Visit - a visit equals PT services received in one day per provider. The PT service limit applies regardless whether the recipient has the same AHCCCS health plan or changes plans during the contract year.

Setting - Any outpatient place of service. (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

Dual Eligible (Non-QMB Dual) - An individual who is Medicare and Medicaid eligible with income above 100% FPL. The individual does not qualify for the federal QMB program.

QMB Dual -An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL. The individual does qualify for the federal QMB program.

Physical therapy prescribed only as a maintenance regimen is excluded.

Authorized treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the recipient's treatment

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

Speech Therapy

A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified Speech-Language Pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his or her individual NPI number. (A group ID number can be utilized to direct payment) SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

AHCCCS covers medically necessary speech therapy services provided to all recipients who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the recipient's PCP or attending physician for FFS recipients.

Speech therapy provided on an outpatient basis is covered only for recipients receiving EPSDT services, KidsCare and ALTCS recipients.

Speech therapy by qualified professionals may include the list below:

1. Articulation training
2. Auditory training
3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.

Respiratory Therapy

Respiratory therapists must be billed with the code
S5180 Home health respiratory therapy, initial evaluation

Respiratory therapists may not use CPT codes 94010 - 94799.

Physicians and hospitals may use CPT codes 94010 - 94799.

No outpatient rehabilitation services are covered for FESP recipients.

Therapy Services Prior authorization requirements:

AHCCCS covers occupational, physical, respiratory, and speech therapy services, that are ordered by a Primary Care Physician (PCP), prior authorized by the Tribal ALTCS Case Managers and provided by or under the direct supervision of a licensed therapist.

Members residing in their own home, an HCB approved alternative residential setting or an institutional setting may receive physical, occupational, and speech therapies through a licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational or speech therapist in independent practice, as applicable.

Services require a Primary Care Provider (PCP) or attending physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's PCP or attending physician.

For acute care the following written documentation must be received by the ALTCS Case Manager prior to the issuance of a PA number:

1. Nature, date, extent of injury/illness and initial therapy evaluation
2. Treatment plan, including specific services/modalities of each therapy, and
3. Expected duration and outcome of each therapy provided.

Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.

Progress notes may be requested by the ALTC Case Manager as evidence of recipient progress for continued authorization (when there is no concurrent review).

Billing for Services

HCBS providers must bill for services on a CMS 1500 claim form. Claims for services will be compared with the case manager's authorization for the services. The match criteria includes:

- Provider ID
- Recipient ID
- Date(s) of Service
- Procedure Code
- Units of Service

If a nursing facility, HCBS, or therapy claim does not match the information on the Case Manager Service Plan, the claim will be denied.

ALTCS Dental Services

Effective date of service 10/01/2016 the dental benefit has been restored for ALTCS recipients age 21 and older for medically necessary dental services.

ALTCS recipients may receive medically necessary dental benefits up to $1,000.00 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventative care. The dental policy for ALTCS recipients under age 21 is described in the FFS Chapter 10 and AMPM Policy 430.

ALTCS recipients are eligible for services as outlined in FFS Chapter 10 and AMPM Policy 310-D1 for recipients age 21 and older. Services that fall into the exception for

transplant and cancer cases as outlined in the above chapter and policy would not count towards the $1,000.00 limit.

The contract year limit is recipient specific and remains with the recipient if the recipient transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. It is the responsibility of the ALTCS Contractor or the Tribal ALTCS Case Manager transferring the recipient to notify the receiving entity regarding the current balance of the dental benefit. Refer to AMPM Policy 310-D2 for transition information and forms.

Benefit coverage and limitations:

- unused benefit dollars do not “carry over” into the next contract year
- dental services performed by Indian Health Service (IHS) or 638 Tribal facility are also subject to the $1,000.00 limit
- frequency limitations and services that require prior authorization still apply
- dentures are covered and will count towards the $1,000.00 limit
- general anesthesia will be covered and will count towards the $1,000.00 limit
- physician performing general anesthesia on an ALTCS recipient for a dental procedure will be covered and will count towards the $1,000.00 limit

In rare instances an ALTCS recipient may have an underlying medical condition that necessitates that services provided under the ALTCS dental benefit be provided in an Ambulatory Surgical Center (ASC) or an outpatient hospital and may require general anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000.00 limit.

Informed Consent

Informed consent is a process by which the provider advises the recipient/recipient’s representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

1. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.

2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/member's representative receiving a copy of the complete treatment plan.

All providers will complete the appropriate informed consents and treatment plans for AHCCCS members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member and/or member's representative.

This requirement extends to all mobile unit providers. Consents and treatment plans must be in writing and signed/dated by both the provider and the patient, or patient's representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. §14-5101). Completed consents and treatment plans must be maintained in the members' chart and are subject to audit.

Notification Requirements for Charges to Members

Providers will provide medically necessary services within the $1,000 allowable amount. In the event that medically necessary services are greater than $1,000, the provider may perform the services after the following notifications take place.

In accordance with A.A.C. R9-22-702 (Charges to Members), the provider must inform/explain to the member both verbally and in writing, in the member's primary language, that the dental service requested is not covered and exceeds the $1,000 limit. If the member agrees to pursue the receipt of services:

1. The provider must supply the member a document describing the service and the anticipated cost of the service.

2. Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeds the $1,000 limit.

Billing for ALTCS Dental Services

Dentists performing services in an IHS or 638 clinic facility will be billed on the UB-04 with revenue code 0512 and the AIR amount by the IHS or 638 facility. Dental treatment record must be submitted with the claim.

Physicians performing general anesthesia will bill on the CMS 1500 with the appropriate CPT/HCPCS codes. Reimbursement will be subject to the FFS Physician fee schedule.

Ambulatory Surgical Center will bill on the CMS 1500 with the appropriate CPT/HCPCS codes and modifiers. Reimbursement will be subject to the FFS ASC fee schedule.

Outpatient facility surgical services will be billed on the UB-04 with appropriate revenue codes and CPT/HCPCS codes. Reimbursement will be subject to the FFS OPFS pricing.

Share of Cost (SOC)

ALTCS recipients who receive long term care services may be responsible for paying a portion of the cost of their care. This payment liability is called share of cost (SOC).

The SOC calculation is a final step in the completion of the ALTCS application. SOC is calculated by subtracting certain expenses and deductions from the recipient's gross income. Calculations differ for recipients residing in nursing facilities and those receiving HCBS.

HCBS recipients have a personal needs allowance deducted from their income which usually is equal to the maximum income allowed for eligibility. Therefore, these recipients rarely have a SOC. Occasionally, an HCBS recipient will have income that is not counted toward eligibility in addition to other types of income or may receive a reduced personal needs allowance. In this case, the recipient may have a SOC.

Recipients in a nursing facility have a personal needs deduction of 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

Deductions for spousal, family, or home maintenance; medical insurance premiums; and non-covered medical expenses may reduce the amount of a recipient's SOC. Because a recipient's income and expenses may fluctuate from month to month, SOC is calculated monthly.

Illegal incentives/Remunerations

Providers offering gift cards, free lunches or other cash in kind inducements to have the recipient select their services are prohibited by Federal Criminal Penalties Statute 42 USC 1320a-7b(b)(2).

Among other activities not permitted, this law prohibits individuals from (knowingly and willfully) offering or paying any remuneration, whether it is cash or in kind, to anyone for the purpose of inducing that individual to order or arrange for any service or item for which payment may be made by a federal health care program, including Medicaid. The offer or payment may be direct or indirect. Such conduct is considered a felony with the possibility of imprisonment up to 5 years as well as a fine not to exceed $25,000.

Revisions

Date	Revisions	Page
10/06/2016	New format Update Physical Therapy visit limit to conform to AMPM ALTCS Dental Services added, effective 10/01/2016 service date	All 8 11
12/18/2013	Reformatting Updated ALTCS office listing	All Exh 14-2